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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 07/06/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology And Pain Management

Description of the service or services in dispute:

Right transforaminal epidural steroid injection

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a female who reported right leg pain. The mechanism of injury was a trip, twisting sharply, and felt a severe pulling sensation in her right buttocks. Treatment to date includes physical therapy, hydrocodone, and muscle relaxants. Per the clinical report dated X/XX/XX, an MRI revealed discogenic changes at L3-4, and L5-S1. On X/XX/XX, the patient reported severe pain in her low back radiating down her right leg to her right knee with electrical shooting dysesthesias, and numbness and tingling. The patient reported weakness in her leg. The patient had not been able to return to work. Medications included ibuprofen 800 mg, lisinopril 10 mg, Zanaflex, and Norco 10/325 mg. Physical exam revealed marked increased pain with minimal flexion, extension; significantly increased pain with lateral tilt, rotation right greater than left. Sitting straight leg raise was positive on the right. The patient had difficulty standing from a sitting position; her gait was antalgic. Motor strength was difficult to assess, and examine in the right lower extremity secondary to pain. There was give way of hip flexors, extensors, and abductors. Deep tendon reflexes were noted as right knee 0, left knee 1+, right ankle 0, and left ankle 1+.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical notes submitted for review, the patient reported injury on XX/XX/XX. There was no evidence the patient had been treated with conservative care, to include physical therapy. On the clinical note dated X/XX/XX, the physician noted the patient had been evaluated for physical therapy, but it has not yet started. On X/XX/XX, the patient continued to report severe pain in her low back radiating down her right leg to her knee with electrical shooting dysesthesias, numbness and tingling. The MRI of the lumbar spine was not provided. However, on X/XX/XX, the physician noted an MRI revealed discogenic changes at L3-4, and L5-S1. Physical exam from X/XX/XX revealed there was a positive straight leg raise on the right, and decreased deep tendon reflexes of the right lower extremity. The Official Disability Guidelines state the purpose of epidural steroid injections is to reduce pain, and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use, and avoiding surgery; but this treatment alone offers no significant long term functional benefit. The guidelines further state epidural steroid

injections are recommended when initially unresponsive to conservative treatment, to include physical therapy. As noted above, there was no evidence the patient had trialed, and failed conservative care, to include physical therapy. Additionally, physical exam failed to reveal the patient had difficulty with heel/toe walk; there was no evidence of sensory loss down medial leg down to the medial surface of the 1st toe. There was no evidence of weakness of the extensor hallucis longus, and there was no sensory loss of the lateral leg, and dorsum of foot noted. It is noted the patient had decreased deep tendon reflexes, to include the patella. However, given the lack of documentation, the request is not supported. Moreover, the guidelines recommend epidural steroid injection when there is evidence of herniated nucleus pulposus on MRI. There was no documentation of herniated nucleus pulposus on MRI at the level requested. Given the above, the previous determination is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)